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Service Provider Knowledge, Misconceptions, and Bias About Aging: A Case for Professional Development

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The number of older Americans (65+), some 33.9 million persons in 1996, increased by 2.6 million (8%) since 1990. Demographics suggest accelerated growth in this segment of the population over the next two decades. Older Americans are projected to constitute 20% of the U.S. population by the year 2030 (Profile, 1997).

Income, poverty, housing, health, and health care data suggest an expanding demand for institutional, community, and home-based services for the elderly (Binstock & Shanas, 1985; Birren & Schaie, 1990; Kahana, 1987; Profile, 1997; Schneider & Rowe, 1990). Social services professionals will work with elderly persons, directly or in teams, as they access health care, social support, public welfare, and educational programs (Palmore, 1993).

Conditions of the Elderly

"Most older persons have at least one chronic condition, and many have multiple conditions" (Profile, 1997). Biological research on aging suggests changes with age in anatomical, nervous system, immunological, and organ functions, while psychological research shows patterns of decline in terms of motivation, activity, memory, learning, motor performance, sensory perception and intellectual abilities (Palmore, 1993). Differential effects by individual may be expected in the course of aging. "Aging can produce both positive and negative results....[It] can bring wisdom or senile dementia, perspective or anxiety, skill or infirmity" (Atchley, 1991, p. 64).

Proportions of the elderly population living in family settings decrease with age. Some 10 million non-institutionalized older persons lived alone by the mid 1990s; a situation associated with increased vulnerability to economic impoverishment, social isolation, and premature placement in care facilities (Matcha, 1997; Moon & Mulvey, 1996). Self assessments of elderly living in the community reveal that 28 percent consider their health conditions as either fair or poor. Blacks were almost twice as likely to report declining health as were Whites (Profile, 1997).

Scenarios considerate of these and other conditions of life in later years (Gelfand, 1993; Manton & Soldo, 1985; Soldo & Agree, 1988) suggest that most older people are likely to depend, at some point in time, on the assistance of one or more qualified service providers (professionals assumed to have realistic and factually based views of the objective circumstances of older persons).

Assessing Service Provider Knowledge

Service providers' knowledge about the elderly may temper attitudes and impact relationships with clients. Attitudinal research on aging and the elderly, given the multidimensionality of attitudes (Hicks, Rogers, & Sherberg, 1976), frequently confronts problems associated with the establishment of valid and reliable means for measurement (Hickey, Bragg, Rakowski, & Hultsch, 1978-79; Kogan, 1979). Related questions may emerge about the utility of attitudinal measures in terms of their linkage with behavioral indices.

Tests of knowledge about the elderly, alternatively, are supported by documented, factual statements which are less subject to criticisms of selective content bias and subjective assertions. Tests which cover basic information and common misconceptions about aging, despite their limited purposes, may have particular utility in the process of decision making related to program staffing, and in the design and development of in-service learning opportunities.

The Study

The purpose of this study was to assess the knowledge of some basic facts about aging among a population of social services providers in one

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state, to identify misconceptions about aging, and indirectly to measure anti-aged or pro-aged bias in an effort to ascertain developmental needs of providers. The knowledge base in the study instrument includes basic factual information about physical, mental, and social dimensions of aging.

Method

The instrument used in the study is a 25-item true-false scale (Palmore, 1988) with items selected from a range of content areas related to aging (Table l). "The instrument was developed as a reaction to problems with other perceptual measures, such as length and mixture of opinion and factual items" (Tavish, p. 547), and "represents an important clarification of the opinion-fact mix in stereotypic research" (p. 549).

Evidence for item validity includes statistics and findings from related research including national and local studies (Palmore, 1988). A review of recent research in content areas represented on the instrument (Birren, 1996; Palmore, 1993; Rowe, 1997; Schneider & Rowe, 1990) suggested no significant deviation from the research basis provided by Palmore (1988) as evidence of the truth of the items. The instrument's purpose is primarily "edumetric"; it is designed to yield measurements that are interpretable in terms of performance standards. Here, the standard is the capacity to determine the truth or falsity of statements on aging (Palmore, 1988).

Table 1: FAQ Statements

1. The majority of old people (age 65+) are senile (have defective memory, are disoriented, or demented).
2. The five senses (sight, hearing, taste, touch, and smell) all tend to weaken in old age.
3. The majority of old people have no interest in, nor capacity for, sexual relations.
4. Lung vital capacity tends to decline in old age.
5. The majority of old people feel miserable most of the time.
6. Physical strength tends to decline in old age.
7. At least one-tenth of the aged are living in long-stay institutions (such as nursing homes, mental hospitals, homes for the aged, etc.).
8. Aged drivers have fewer accidents per driver than those under age 65.
9. Older workers usually cannot work as effectively as younger workers.
10. Over three-fourths of the aged are healthy enough to carry out their normal activities.
11. The majority of old people are unable to adapt to change.
12. Old people usually take longer to learn something new.
13. It is almost impossible for the average old person to learn something new.
14. Older people tend to react slower than younger people.
15. In general, old people tend to be pretty much alike.
16. The majority of old people say they are seldom bored.
17. The majority of old people are socially isolated.
18. Older workers have fewer accidents than younger workers.
19. Over 15% of the population are now age 65 or over.
20. The majority of medical practitioners tend to give low priority to the aged.
21. The majority of old people have incomes below the poverty line (as defined by the federal government).
22. The majority of old people are working or would like to have some kind of work to do (including housework and volunteer work).
23. Old people tend to become more religious as they age.
24. The majority of old people say they are seldom irritated or angry.
25. The health and economic status of old people will be about the same or worse in the year 2000 (compared to younger people).

Descriptive statistics were computed for all test items, and additional item-by-item computations were made by location of respondent practice (urban/rural) and by organizational classification of respondents (SW II/SW III). Pro-aged/anti-aged bias scores and a net total were calculated using Palmore's (1988) schema where the percentage of errors on the negative bias items (1, 3, 5, 7, 8, 9, 10, 11, 13, 16, 17, 18, 21, 22, 24, 25) are subtracted from the percentage of errors on the positive bias items (2, 4, 6, 12, 14). A negative score indicates a net anti-aged bias. A positive score indicates a net pro-aged bias. Variance statistics (ANOVA) were computed to test for significant differences ($p < .05$) in anti-aged or pro-aged bias by each of the independent variables (status, location, sex, age, education, experience in social work, work with older (65+) clients, and experience with older clients) included in the study.

The instrument was made available to a respondent universe consisting of all direct service providers (N=391) in one state. These personnel were classified as either Social Worker II (SW II) or Social Worker III (SW III). SW IIs provide protective treatment services to dependent adults, case management and social work service, and act as resource personnel in terms of service needs of the elderly. SW IIIs have major responsibilities for conducting investigations related to abuse and the denial of critical care, and for reporting findings to the appropriate authorities.

Results

Study data were derived from 281 instruments (72%) which were returned and completed. The distribution ratio of instruments returned, 2.4 (SW II) to 1 (SW III), was generally proportional to the distribution of employees by job classification in the respondent universe. Respondents were predominantly female (75%), in their 20s and 30s (66%), and held a bachelor's degree or above (97%). Half of the respondents had over 7 years of experience in social work, with only 6% reporting less than one year of experience. A large majority (78%) had worked with older (65+) clients for a year or more, and a substantial minority (46%) indicated experience with older clients extending over three years or more.

To identify frequent misconceptions among this population, descriptive statistics were computed. The mean percentage of errors on each statement for the total population appear in Table 2. The error rate on almost one-half of the items was at or above 40%, while the error rate on one-third of the items exceeded 50%. Statements about aging related to current status, trends and conditions (social dimensions) which were documented as factually false, but were deemed correct by a majority of respondents, included: #7.

Table 2: Percentage of Errors on Each Statement by SWII and SWIII

Statement	Urban (N=130)	Rural (N=151)
1	.0	2.0
2	50.8	60.3
3	2.3	.7
4	37.7	48.3
5	.8	2.6
6	9.2	5.3
7	46.9	53.6
8	38.5	41.1
9	11.5	7.3
10	62.3	61.6
11	13.8	17.2
12	60.8	65.6
13	.0	.7
14	8.5	6.6
15	1.5	.7
16	50.8	63.6
17	24.6	33.1
18	29.2	29.1
19	86.9	92.1
20	37.7	47.7
21	59.2	62.9
22	10.8	5.3
23	49.2	41.1
24	65.4	67.5
25	17.7	26.5

At least one-tenth of the aged are living in long-stay institutions (such as nursing homes, mental hospitals, homes for the aged, etc.) #19. Over 15% of the U.S. population are now aged 65 or over; #21. The majority of old people have incomes below the poverty level line (as defined by the federal government).Certain psychologically and physiologically related statements (2, 12, 16, 24) which were documented as factually true, attracted incorrect responses by a majority of respondents. They did not believe that: #2. The five senses (sight, hearing, taste, touch, and smell) all tend to weaken in old age; #12. Old people usually take longer to learn something new; #16. The majority of old people say they are seldom bored; and #24. The majority of old people say they are seldom irritated or angry.

Table 3: Percentage of Errors on Each Statement by SWII and SWIII

Statement	SWII (N=19)	SWIII (N=82)
1	1.6	2.0
2	54.5	61.5
3	1.6	.0
4	44.5	44.9
5	2.1	.0
6	5.8	11.5
7	53.9	41.0
8	41.4	37.2
9	8.9	10.3
10	40.3	29.5
11	16.2	12.8
12	64.9	64.1
13	.5	.0
14	7.9	6.4
15	1.6	.0
16	60.7	51.3
17	30.9	21.8
18	28.8	30.8
19	90.1	92.3
20	44.0	43.6
21	61.8	57.7
22	4.7	15.4
23	45.0	44.9
24	66.0	67.9
25	22.5	23.1

When the data were examined in terms of location of service/provider practice (urban/rural), it was found (Table 2) that those social workers practicing in rural environments made more errors in terms of statements misconceived by a majority of the total population. Analysis of the distribution of errors by organizational status (Table 3) suggested no particular trend in terms of differences between groups on the most frequently misconceived statements.

An indirect measure of respondent bias (pro-aged/anti-aged) was obtained by computation of net anti-aged or pro-aged bias scores for each of the independent variables included in the study (Table 4). Net pro-anti bias scores suggest a neutral to marginally positive perspective of the elderly among study respondents. Additional analyses of variance were performed to identify significant differences in pro- and anti-aged bias in terms of each of the independent variables. No significant differences were found.

Discussion

Service providers responding to the study instrument may be characterized as young, well-educated, predominantly female professionals with some direct work experience with older clients. Generally held misconceptions about aging and the elderly appear to converge in the areas of socioeconomic conditions and psychological/physiological circumstances. Error rates on test statements related to socioeconomic conditions suggest that these service providers may view the size of the potential service population as larger than actual data support, and that they may perceive problems of the elderly as more extensive and severe than current research would confirm. Service providers' errors on instrument statements which overestimate actual numbers are exemplary of the suggested tendency among these providers; a majority of whom thought, for example, that at least one-tenth of the aged are living in long-stay institutions (actual=4%); that over 15% of the U. S. population are now age 65 or older (actual=12.8%); and that the

Table 4: Pro- and Anti-Aged Errors for Each Independent Variable

Group	Pro-Errors Mean%	Anti-Errors Mean%	Pro-Anti (Net)* Mean%
Status			
SWII	35.5	28.8	6.7
SWIII	37.7	27.5	10.2
Location			
Urban	33.4	27.1	6.3
Rural	37.2	29.7	7.5
Sex			
Male	34.7	24.7	10.0
Female	35.8	29.8	6.0
Age			
<30	35.5	32.4	3.1
30's	39.7	29.1	10.6
40's	30.0	26.9	3.1
50's	28.9	22.2	6.7
60+	37.5	26.6	11.0
Education			
High School	24.0	43.8	-19.8
Bachelors	36.8	28.6	8.2
Bachelors+	34.2	28.0	6.3
Masters	33.3	27.1	6.3
Experience in Social Work			
<1 Year	40.0	34.6	5.4
1-3 Years	37.5	29.1	8.4
3-5 Years	35.4	29.5	5.9
5-7 Years	38.6	29.5	9.1
8+ Year	33.9	27.3	6.6
Work with Older (65+) Clients			
Yes	36.5	28.5	8.0
No	32.8	28.9	3.9
Experience with Older Clients			
Up to 1 Year	33.3	35.4	-2.1
1-3 Years	36.8	29.2	.6
3-5 Years	41.5	28.9	12.7
6+ Years	35.4	27.0	8.4

*Net bias percent within a range of + 20 indicates neutral position.

majority of older people have incomes below the poverty line (actual=10.8%) (U. S. Bureau of the Census, 1992, 1995; Profile, 1997). Results in this study do not suggest any significant increment over time in terms of knowledge about aging among social workers (Barresi & Brubaker, 1979; Levy & West, 1985).

Errors by a majority of respondents on items related to psychological circumstances suggest somewhat idealized views of the elderly, on one hand, and beliefs in common negative stereotypes on the other. Contrary to findings of related research, a majority of respondents thought that the elderly did not take longer to learn something new (Bostwinick, 1967; Palmore, 1993), and that all five senses did not tend to decline in old age (Birren, 1959; Schneider & Rowe, 1990). Stereotypes appear to have contributed to misconceptions among providers who did not believe that the majority of old people are seldom bored (Dean, 1962; Harris, 1975), and that the majority of old people are seldom irritated or angry (Dean, 1962; Palmore, 1993).

The tendency toward a pro-aged bias among respondents, although marginal, may reflect some unrealistically favorable views of aging. Attention to pro-aged views is warranted, especially where service provider perspectives may affect estimates of client service needs. Pro-aged views may be reinforced by agency strategies employing clients' strengths in devising interventions. Care must be taken to assess accurately client capacities; especially among older adults whose functional conditions may change rapidly.

The study population of service workers is limited and may not be representative of the larger universe of providers. Nonetheless, findings do raise questions about how relative accuracy and extent of knowledge about a client population may condition provider perceptions, attitudes, beliefs, and behaviors.

As intentional, active agents in interactional processes involving the elderly, service providers interpret situations and assign meanings to them; interaction in the work environment involves cognitive processes influenced by both substantive insights and social learning (Endler & Magnusson,

1976). Stereotypic perceptual composites of the elderly founded, in part, on misconceptions or misinformation may induce inappropriate action and reactions as providers address service needs of elderly clients. Inaccurate composites of older persons in terms of physiological and social characteristics may impact objectivity in decision making, and predispose an individual provider to deal with clients in a routine or general manner, or on the basis of emotional liking or disliking. Where there are preferences for relationships with younger people (Harris, 1975) and generally negative attitudes toward aging and the elderly, however, they may be no more deleterious in terms of impact on the level of rationality brought to the service arena than an assumption of the elderly as inordinately capable (Atchley, 1991).

There is widespread disagreement on many issues related to the elderly and aging. Will the elderly of the future experience more of a compression of morbidity and be able to live virtually all of their lives in good health (Fries, 1993)? Will the elderly of the baby boomer generation be more economically advantaged to a point where there will be less demand on public funds for services to the elderly (Birren, 1996)? Controversial issues and changing social, economic, and demographic circumstances of aging and the elderly may be expected to stimulate challenges to existing paradigms and public policy (Scharlach & Kaye, 1997).

Social services providers may expect to work with elderly clients in resource-constrained, fluid environments replete with sociopolitical uncertainties impacting service delivery. In the course of decision making in such environments, they will depend on the stability-inducing effects of a factual base of knowledge regarding the objective realities of older Americans. Structured and unstructured continuing learning opportunities for service providers can enable the acquisition and maintenance of practice-related baseline knowledge about aging and the elderly. The case for investment in such opportunities is axiomatic.

Regional workshops, conferences, and courses delivered via distance learning systems may be useful as vehicles for providing up-to-date information to dispersed populations of service providers at the state level. Case/care manager meetings also may serve as opportune venues for substantive learning. Networking with other professionals serving the elderly (health care workers, therapists, and directors of senior centers, for example) may offer additional opportunities to share knowledge and insights.

Effective practice is constrained by limited knowledge of particular service populations. The provision of appropriate services to the elderly depends, in part, on sound decisions mediated by factual knowledge. Findings of this study suggest the need for additional inquiry into providers' knowledge of distinctive service populations with special needs.

REFERENCES

Atchley, R. (1991). *Social forces and aging*. Belmont, CA: Wadsworth Publishing.

Barresi, C., & Brubaker, T. (1979). Clinical social workers' knowledge about aging: Responses to the "Facts on Aging Quiz." *Journal of Gerontological Social Work*, 2, 137-146.

Binstock, R., & Shanas, E. (Eds.). (1985). *The handbook of aging & the social sciences*. New York: Van Nostrand.

Birren, J. (Ed.). (1996). *Encyclopedia of gerontology*. San Diego: Academic Press.

Birren, J., (Ed.). (1959). *Handbook of aging and the individual*. Chicago: University of Chicago Press.

Birren, J., & Schaie, K. (Eds.). (1990). *Handbook of the psychology of aging*. New York: Van Nostrand.

Bostwinick, J. (1967). *Cognitive processes in maturity and old age*. New York: Springer.

Dean, L. (1962). Aging and decline of affect. *Journal of Gerontology*, 17, 440- 446.

Fries, J. (1993). Compression of morbidity: Facts and research. *Gerontology*, 7, 183-190.

Harris, L. (1975). *The myth and reality of aging in America*. Washington, DC: National Council on Aging.

Hickey, T., Bragg, S., Rakowski, W., & Hultsch, D. (1978-1979). Attitude instrument analysis: An examination of factor consistency across two samples. *International Journal of Aging and Human Development*, 4, 359- 375.

Hicks, D., Rogers, C., & Sherberg, K. (1976). Attitudes toward the elderly: A comparison of measures. *Experimental Aging Research*, 1, 119-124.

Kogan, N. (1979). Beliefs, attitudes and stereotypes about old people: A new look at some old issues. *Research on Aging*, 1, 11-36.

Levy, W., & West, H. (1985, Oct. 19). Knowledge of aging in human service professions. Paper presented at the annual meeting of the Texas Chapter, National Association of Social Workers, Dallas, TX.

Maddox, G. (Ed.). (1987). *The encyclopedia of aging*. New York: Springer.

Manton, K., & Soldo, B. (1985). Dynamics in health changes in the oldest old. *Health and Society*, 63, 206-275.

Matcha, D. (1997). *The sociology of aging*. Boston: Allyn & Bacon.

Moon, M., & Mulvey, J. (1996). *Entitlements & the elderly*. Washington, DC: Urban Institute Press.

Palmore, E. (1976). The future status of the aged. *Gerontologist*, 16, 297-302.

Palmore, E. (1977). Facts on aging. *Gerontologist*, 17, 315-320.

Palmore, E. (1988). *The facts on aging quiz*. New York: Springer Publishing.

Palmore, E. (1993). *Developments & research on aging: An international handbook*. Wesport, CT: Greenwood Press.

Profile of Older Americans (1997). Report based on U.S. Bureau of Census data. Washington, DC: AARP.

Riley, M., & Foner, A. (1968). *Aging and society*, 1, New York: Sage.

Rowe, J. (1997). Successful aging. *Gerontologist*, 37, 433-440.

Scharloch, A., & Kaye, L. (1997). *Controversial issues in aging*. Boston: Allyn & Bacon.

Schneider, E., & Rowe, J. (Eds.). (1990). *Handbook of the biology of aging*. San Diego: Academic Press.

Soldo, B., & Agree, E. (1988). America's elderly. *Population Bulletin*, 43(3). Washington, DC: Population Reference Bureau.

Tavish, D. (1982). Perceptions of old people. In D. Mangen & W. Peterson (Eds.), *Research instruments in social gerontology*. Minneapolis, MN: University of Minnesota Press.

U.S. Bureau of the Census. (1992). Current population reports. Population estimates and projections, Series P-25, No. 1818, January. Washington, DC: U.S. Government Printing Office.

U.S. Bureau of the Census. (1995). Statistical brief, SB/94-33, January. Washington, DC: U.S. Government Printing Office.